STATE OF ILLINOIS
OFFICE OF THE GOVERNOR
SPRINGFIELD, ILLINOIS 62706

Pat Quinn
GOVERNOR

Health Care Reform Implementation Council Meeting
Wednesday, September 25 2013
10:00 am-12:00 pm
James R. Thompson Center, Room 9-040, Chicago
Stratton Building, Capitol Development Board, 349-C, Springfield

Council Members: Michael Gelder, Cristal Thomas, John Holton, Michelle Saddler, Julie Hamos, Andrew Boron, Laura Zaremba, Mike Moss, LaMar Hasbrouck

I. Approval of minutes

Director Holton created the motion with Director Hamos seconding. Minutes unanimously approved after no objection.

II. ACA Implementation

Insurance Plans on the Marketplace – Director Andrew Boron, Department of Insurance

Three outside consultants will discuss (presentation). Wayne Johnson went through highlights of presentation rather than cover every slide. Gave outline of requirements for plans. In essence 5 types of plans [metal levels] - will all provide same coverage, but out-of-pocket costs may vary depending on particular plan. Bronze plan will have lowest initial premiums, platinum will have highest. There are different rating areas within the state, map of those areas. Several companies offer plans on exchange, some available on state-wide basis. A number of companies offered plans in each rating area. At least 3 offering in every rating area in the state - only one with just 3, 4 or 5 in every other area. Good foundation for availability of coverage.

Beth w/ Oliver Wyman - walked through additional slides. Rates in IL were about 25% less than what HHS expected. Chicago area in dark blue about $264, Peoria $312 - HHS had estimated $392. Chicago is more than 25% less, Peoria a little less than 25% less. Next example is impact of federal subsidies can have on premiums actually paid. Chicago area - a 30 y/o w/ income about $23k, based on federal formula that person will pay $121 per month, even though in Chicago second lowest silver is $188 and in Peoria $222, they will only pay $121. Could also use subsidy to buy down to Bronze and pay even less.

Gelder - let me just say in terms of what people's OOP costs will be, we have to look at both the premium and the subsidy set up in ACA based on income, so that net cost is real key for the public to understand what they're costs will really be.

Boron - IL rates less than other states and IL rates less than CBO projections.

Hamos - State the obvious that there is tremendous amount of choice, we look forward to hearing about public education to help guide public through selection.

Gelder: While still on DOI, wanted to raise to council some of the real issues behind the plan rates and availability, what public and press have focused on and will be key approaching OCt 1. Everything in health care system in state of flux - we have the Alliance which was set up recognizing existing system and costs and quality of care are not satisfactory, we need to attend to reform of the delivery system. Given state of flux, one issue is how do we measure outcomes? We've all adopted in industry and government that value is one way we want to measure, but how? We know how to measure volume because we've done that for decades - we know how many patients and visits there are. Value is more complicated and previous assumptions need to be reexamined. Issue of provider adequacy is important - DOI had to test for. We assume more doctors in a plan is better, which we now know that more care may not be better care, more prescriptions can start to interfere with other prescriptions. So, goal is to get it just right - number of providers to give access. DOI has struggled with question of network adequacy for HMOs and PPOs and the new EPOs that some insurers are interested in. I'd like Andrew and staff to share some of these issues so we can understand what direction the industry is going, how we can make sure we have enough providers available as insurers work to hold down costs.

Boron - All the plans underwent network adequacy review, we believe all the plans offered have sufficient network opportunities. I will turn it over to team in Springfield to discuss.

Jim - In the beginning we talked about the goal of culture of coverage and improving health, there was also the issue of provider adequacy and value. Of course value is something that's outcome based. Balanced billing and cost sharing, financial solvency - all these things are what need to be in the plan, and we check to be sure culture of coverage is something that's accepted by consumers. When it comes to emergency services, those involve network accessibility and allows for use of emergency services outside of network - that's a good thing. What we need to look out for there is what is the enrollee going to be charged for OON emergency services? If they are only reimbursed at rate of in-network provider they may have balance. Then issue of cost-sharing - particularly relevant to managed care, HMO. A lot of managed care have very high cost sharing, co-pays, which act as disincentive to use medical services.

Gelder - Under our purview is how we as a state consider overall goal of holding down premium costs - to do so, insurers are looking at narrower provider arrangements. We're also interested in quality and sufficiency, so how we approach finding the right balance is a new calculus for us, which involves DPH because they help assure network adequacy.

Michelle Oshman- Jim did well to point out that any plan has to make provisions for out of network coverage for emergencies, but we should keep in mind concept of portability. I myself moved to Springfield - so networks might need to give people access options in other parts of the state, i.e. if someone has a kid going to college elsewhere in the state.

C. Thomas - I understand there's also an OOP cap, depending on your income level. Those at higher can't pay more than 9.5% - does that apply only to premium or all cost sharing, and if latter how tracked?

Michelle Oshman - doesn't apply to OOPM - will be some cost sharing and some adjustments. From what I understand will be run through system of what they qualify for, to reduce cost sharing on their end.

Outreach and Education – Brian Gorman, Outreach and Education Director, Illinois Health Insurance Marketplace

Brian Gorman- This morning we have an update on marketing efforts and field program, vitally important to educating consumers. Challenges in front of us - we knew awareness was low, people we needed to enroll for coverage was low. 4 out of 5 across the country didn't know what the Marketplaces are - not confusion about details, but unaware. So how do we tackle awareness? Procurement process we have partnered with Fleishman Hillard who are providing webpage, support for us on the ground, digital strategies. We are excited to announce the new brand for IHIM - Get Covered Illinois, the official new brand name. There's been tremendous interest internally and externally, so we're very excited. Get Covered is a call to action. Get Covered Illinois will help consumers know what options are and financial help.

Integrated multimedia campaign starting now designed to help consumers understand options. Additional advertising will be phased in through Dec 15 - key date for coverage. There has been emphasis on Oct 1 but we really have target of Dec 15 to make sure everybody has opportunity to have coverage starting Jan 1.

We'd like to talk more about our field program - we know awareness is not enough. Cultural, historical barriers to reaching people we need to enroll and we need them to take action. We've divided state into 10 regions with staff member reporting to me - we currently have 8 of 10 and are close to bringing on last 2. Their responsibility is to manage our IPC program in the field. Announced in July 44 lead agencies granted sum of $27 million which also involve sub grantees to serve across the state. When website is launched Oct 1, we know nearly 60% of those enrolling will need some assistance mostly in person, so there will be a tool on website to let consumer search by zip code to find contact info for assisters in their area, also see events like presentations or enrollment effort in their area.

Agent & Broker ambassador program to make sure we reach small business, bring them on board effort to make sure we reach our goal.

Hamos - DHS and HFS will implement Medicaid side - two systems, and also together managing call center assisting Medicaid enrollment. Daily meetings with Gov's office - want to emphasize we will need to be in close contact with media efforts, so call center is prepared for volume from advertising.

Brian: agencies have been highly communicative, we recognize this is coordinated campaign effort - concentric circles of overlap, we have to make sure we're working together. We want to make sure DHS and HFS have all the information they need as things change. I do want to highlight importance of website launching Oct 1 - there will be screening tool for consumer to enter basic information on family size and income, and triaged to ABE or Marketplace depending on where they probably qualify. Important to be directing people to where they need to go - coordination and communication will be vitally important.

Holton - this has been tremendous effort, kudos. I have some trepidation about emphasis on Oct 1. Evening news says Oct 1 may be government shutdown, lots of importance. What can we do as departments to help you reach your goals of reaching currently uninsured? Question 2, what are you doing to monitor quality of efforts - come Nov 15 you'll have 30 days to target of Dec 15 and 6 weeks since start of campaign, so what will you do to tweak efforts to improve some results, knowing you are likely to get a bit of a rush prior to Dec 15.

Brian - What departments can do to assists, I would turn that to myself and my team to make sure very department in state has information to direct consumers to where they need to go. Monitoring and evaluating and holding ourselves accountable is very important. Some challenges - being a partnership state we won't have the information on those folks who enroll, so there may be many people enrolling day one but we won't know until the feds get that information back to us. One thing we can do is make sure we're tracking every activity, meeting, holding outreach partners accountable - at some point we want to overlay outreach efforts with enrollment. Starting Oct 1 we need to be thoughtful and purposeful about what things went well, what didn't - data driven metrics are important, also want to capture what we can on consumer level.

Medicaid Eligibility and Services - Integrated Eligibility System – Michael Koetting, Deputy Director of Planning and Reform Implementation, Illinois Department of Healthcare and Family Services

Mike Koetting - the Medicaid expansion going fairly well. Most important single piece is ABE - outward facing website, will be up and running Oct 1 - new call center also up and running Oct 1 to handle Medicaid, SNAP, cash assistance because IES handles all of those. A little behind on some other pieces, will be coming up over next couple of days or weeks - all things considered in pretty good shape for next week.

Already way ahead of other states in having number of people enrolled - some through Cook Co. waiver, almost 30k people, another 27k already in the cue, and about 30k more applications preparing to send.

Will all convert to ACA enrollment starting Jan 1 so we'll already have many enrolled. ACA ends old system of only qualifying for Medicaid if in certain categories - taking those categories away means we can easily convert people already on SNAP who are documented as poor and can now qualify, are right now being enrolled and will get Med effective Jan 1.

One item for Aging - if you already have Medicaid or Medicare, you're in good shape and don't need to call us.

We have new desktops for case workers, they were very excited. Already 2k new case workers on new system, additional 300 coming onboard.

Really incredible effort that people don't really know about.

Hamos - ACA gave us a date, we've been working towards that date, rushing to get it done. One other piece of unfinished business is the Alternative Benefit Plan for newly eligible ACA adults. Had thought would be same as offered to adults in family care but some nuances based on feedback from feds. Number 1 - what does "habilitation" mean? Second, category of adults called Medically Frail, need some special consideration - looking at how other states are handling. We are thinking all of this through.

III. Workgroup on Workforce – LaMar Hasbrouck, Director, Department of Public Health

Gelder - I understand we will post-pone consideration of workforce to our next meeting. Quick sentence on what's happening?

Hasbrouck - We've been working, hope to do deep-dive at next meeting and have report next month. We are looking at pipeline programs, looking at short term strategies, technical - hope to roll it all into our report.

IV. Workgroup on Justice Populations – Lisa Braude, DMA Health Strategies and Maureen McDonnell, TASC, Inc.

Dr. Braude - We started this process back in March 2011 when I was working for state of IL. Workgroup convened with understanding that if you design a system for highest-risk highest-need highest-cost citizens, you design a strong system that can meet the needs of the most vulnerable. Yesterday held workgroup on justice pop - common goals; providing coverage to all justice pop members, detainees, those coming out. This pop has inordinate incidences of mental health and substance abuse - coordinating efforts to ensure they receive care they need and reduce costs, impact on public safety. Key decisions rest on finalizing some decisions at agency level. Other piece is the "what's next?" We have coordination and collaboration, having in-dept conversations - what will be provided is series of resource materials - "job aids" to support justice officials on the ground helping identify those who are eligible, helping them enroll. Priority placed on training - including training for health providers giving care to this population. Need to monitor and nurture this effort and discussion - look at the "so what," make sure intense focus continues throughout implementation.

Maureen McDonnell - we have continued work on court and probation side of this effort. Many people don't know about what they are about to be entitled to - about 100k are on probation, and justice agencies probably best way to reach them. We've been working to reach probation officers across the state. We've been in front of 175 probation judges and leaders this summer - they're interested in partnering with IPCs and navigators. Chief Judges have big interest - Chief Judge McGraw lead discussion last week, has asked us to come back and continue conversation. CJ Evans and J Beavle have worked extensively with health and hospital system around CountyCare. We had opportunity to pilot some things - big efforts in enrolling in Cook County Jail, now have almost 600 members who initiated their applications while in jail. Courts thinking about what does a health care reform ready court look like? Looking for increase in health status and decrease in institutional health costs, both state and county.

Sue Pickett - what research to date shows is this is high needs, high risk, high cost population no matter what system they're in. When systems collaborate, everybody wins. Interest and work you are doing will have important outcomes for state down the road, both in terms of costs and health care and corrections status.

Gelder - lots of overlap with the Alliance goals, this is a needs group that would be included, lots of information should be incorporated in Alliance.

Zaremba - specifically work doing around care transition, certainly for those receiving care while in prison then paroled is a care transition that must be considered.

Saddler - this is so important, implementation is really key. Those eligible may be canceled when redetermination letters don't reach them. Periodically I try to look into this - policies at this point are ok, but implementation is so important because it's across systems in different counties. How can we disseminate information on how people are newly enrolled, remain enrolled?

Maureen - appreciate you bringing that up, HFS and DFS have been doing great work. There are probably opportunities with fed funding around eligibility and enroll systems - we'd be happy to reach out to colleagues in other states.

Holton - Can workgroup provide me with info on this population age 60 and over? Particularly difficult group to relocate after being institutionalized.

VI. Public Comments

Leticia Boughton with Health Connect One - Question about managing sufficient work force to provide care, including community health workers: we know Dr Hasbrouck is working on this - what is the state doing? I'm just trying to figure out what is going on - working on legislation to standardize definition, scope of work for community health workers. Also for Brian Gorman - small business right now being pressured to renew their rates and lock in their rates before Oct 1 by insurance companies - how soon is he planning to reach out to small businesses and make sure they are contacted before getting pressured?

Laura P - I'm on Marketplace policy team, working with Brian. Outreach to small businesses is ramping up, ha e had multiple meetings with A&Bs, Agent Ambassador program so they can train their colleagues. As far as insurance companies pressuring small businesses, good thing to relay back to DOI.

Laura P - on Outreach side, Brian is working with SBA - some grantees have small business focus and are in process of getting certified to hit the streets. Marketing through FH will also ramp up.

Holton - What I hear is need to be able to take back some definitive info to give small business who call Senator Hunter or appear wanting to know what they need to do because insurance companies are pressuring.

Latisha: I met yesterday with Senator Hunter who brought up healthcare workforce shortages due to ACA, stressed her concern about not enough providers to take care of newly eligible and enrolled. I mention Sect 5313 providing grants to promote community health workers in underserved communities, so I'm just following up with what the state is doing. I know we have had a meeting with you so I'm just following up.

Hasbrouck - Thank you for that, community health workers will be a part of our reporting recommendations. We've been doing some work and taking a lead as needed to help organize community health workers, borrow best practices from other states. Will have some specific language in report regarding community health workers and ability to reimburse through ACA.

VII. Adjourn